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## PROGRAM PROFILE

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### THE USC CARDIOTHORACIC CENTER

**T**he USC Cardiothoracic Center at USC University Hospital is a combination of innovative programs that offers patients diagnostic and therapeutic cardiac and thoracic services. At the Center, renowned cardiologists, cardiothoracic surgeons, vascular surgeons, anesthesiologists, radiologists and allied medical professionals work as a united team, providing seamless care to patients who may need multiple treatments for life — some involving medicine, some involving surgery.

#### **Comprehensive Cardiology Services**

The USC Cardiothoracic Center offers a comprehensive array of outpatient and inpatient services. The USC Cardiology Outpatient Center, located at USC University Hospital, includes a full-service noninvasive laboratory, risk factor assessment and reduction clinic, and cardiac rehabilitation program interfacing with physical therapy.

The invasive cardiology program assesses adult valvular heart disease, congenital heart disease, coronary heart disease and cardiomyopathy. Diagnostic techniques include angiography, intravascular ultrasound, doppler flow wire measurements of coronary blood flow, and myocardial biopsy. Therapeutic techniques include temporary cardiopulmonary bypass, interaortic balloon counter pulsation, balloon angioplasty, directional atherectomy, transluminal extraction atherectomy, coronary stents, and the latest anti-thrombin medications and thrombolytics.

The electrophysiology program offers several diagnostic techniques such as Holter monitor, signal averaged EKG, tilt tests, and invasive electrophysiological testing. Patients also have access to the new generation of pacemakers, many still experimental, including AICD (automatic defibrillator). USC will be one of the first sites to place AICDs through percutaneous transvenous lines. The program also conducts electrophysiology studies and ablation to regulate the heartbeat.

#### **Cardiothoracic and Transplantation Surgery**

The USC Cardiothoracic Center provides the full range of cardiovascular surgical services, including heart, heart-lung and lung transplantation. Clinical interests of the team include ventricular assist devices and artificial hearts, adult congenital heart disease, end-stage congestive heart failure, pulmonary hypertension, ischemic heart disease and diagnostic and interventional cardiac procedures including intravascular ultrasound. Surgeons perform open heart surgery, aortic, mitral and tricuspid valve replacement surgery, coronary bypass surgery, and incorporate the latest corrective surgical techniques for ventricular and atrial arrhythmias and aortic diseases that involve aneurysms and dissections.

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**University of Southern California**

## Innovative Cardiopulmonary Transplantation

Since its creation in 1993, the USC Cardiothoracic Center team has performed 22 heart, lung and heart/lung transplants, seven of which were living-related lobar lung transplants. The team was the first to successfully perform a double lobar lung transplant from living-related donors on a 21-year-old woman suffering from cystic fibrosis.

The Heart Failure Clinic assesses patients for cardiac transplantation. They are followed by their local cardiologists, and return to USC periodically for continued assessment. Patients also have access to the experimental and approved drugs being developed to treat heart failure. Transplantation patients receive preoperative evaluation and management and postoperative immunosuppression.

## Services

- Pulmonary valve translocation (or Ross procedure) for patients with congenital defective aortas.
- Video-assisted thoracic surgery (minimally invasive).
- Thoroscopic procedures for invasive lobectomies, biopsies, and wedge resections.
- Minimally invasive chest surgery for lung cancer resection using a thoracoscope rather than thoracotomy.
- Designated Center for Southern California Jehovah's Witnesses for "bloodless" open heart surgery.

## Close Contact with Referring Physicians

Specialists at the USC Cardiothoracic Center are dedicated to maintaining close contact and frequent communication with referring physicians throughout the United States.

## The USC Cardiothoracic Center Co-Directors

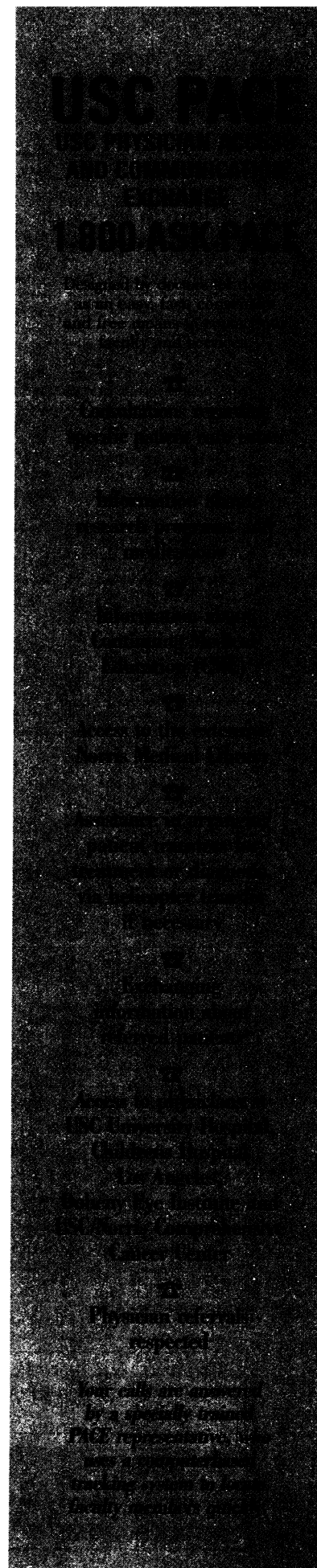


**Vaughn A. Starnes, M.D.**, is Professor of Surgery at the University of Southern California School of Medicine, Chief of the Division of Cardiothoracic Surgery and Director of the USC Cardiothoracic Center at USC University Hospital, Childrens Hospital Los Angeles and Los Angeles County+USC Medical Center. Dr. Starnes earned his bachelor's degree in chemistry and medical degree at the University of North Carolina, Chapel Hill. He completed his general surgery training at Vanderbilt University, and then joined Stanford University, where he completed two years as a resident in cardiovascular surgery and one year as chief resident in cardiac transplantation. He joined USC in 1992.



**David P. Faxon, M.D.**, is Professor of Medicine and Chief of the Division of Cardiology, USC Department of Medicine. A graduate of Hamilton College in Clinton, New York, Dr. Faxon earned his medical degree from Boston University School of Medicine. He completed an internship and internal medicine residency at Mary Hitchcock Hospital, Dartmouth-Hitchcock Medical Center in Hanover, New Hampshire, and returned to Boston University for his cardiology fellowship. He joined the Boston University School of Medicine faculty in 1976, and in 1991 was named Professor of Medicine. He became a member of the USC faculty in 1993.

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**A** C C E S S A N D  
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## SOUTHERN MEDICAL ASSOCIATION



# Spring 1995 CME Calendar

### PRIMARY CARE PROGRAMS

The following programs contain appropriate information for primary care physicians practicing family medicine, internal medicine, obstetrics & gynecology, pediatrics, or geriatric medicine.

**Caring for People With Chronic Health Conditions**

March 24-26, 1995 • Hilton Head Island, SC

**New Drugs Update: A Clinician's Perspective**

March 31-April 2, 1995 • Biloxi, MS

**Rehab & Primary Care:  
Helping People Help Themselves**

April 21-23, 1995 • Birmingham, AL

**National Interactive Video Conference - The Brain At Risk: Preventing, Diagnosing & Managing Stroke**

May 2, 1995

**Musculoskeletal Impairment & Disability Evaluation**

May 12-14, 1995 • New Orleans, LA

**Geriatric Medicine: An Update on Diagnosis & Management**

June 8-10, 1995 • San Antonio, TX

### SPECIALTY PROGRAMS

The following programs contain in-depth information in a particular specialty, but may also be appropriate for primary care or allied health care professionals.

**SEC Sports Medicine Symposium**

**Target Audience: Orthopaedists, Sports Medicine, Primary Care, Sports Trainers, Physical Therapists**

March 9-12, 1995 • Atlanta, GA

**5th Annual Mammography Update**

**Target Audience: Radiologists**

March 12-14, 1995 • Amelia Island, FL

**The Shoulder Symposium**

**Target Audience: Orthopaedic Surgeons**

April 7-8, 1995 • Pine Mountain, GA

**Current Concepts in Orthopaedics**

**Target Audience: Orthopaedic Surgeons**

May 19-21, 1995 • Baltimore, MD

**19th Annual Lung Symposium**

**Target Audience: Pulmonology, Critical Care**

June 11-15, 1995 • Sea Island, GA

The Southern Medical Association is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

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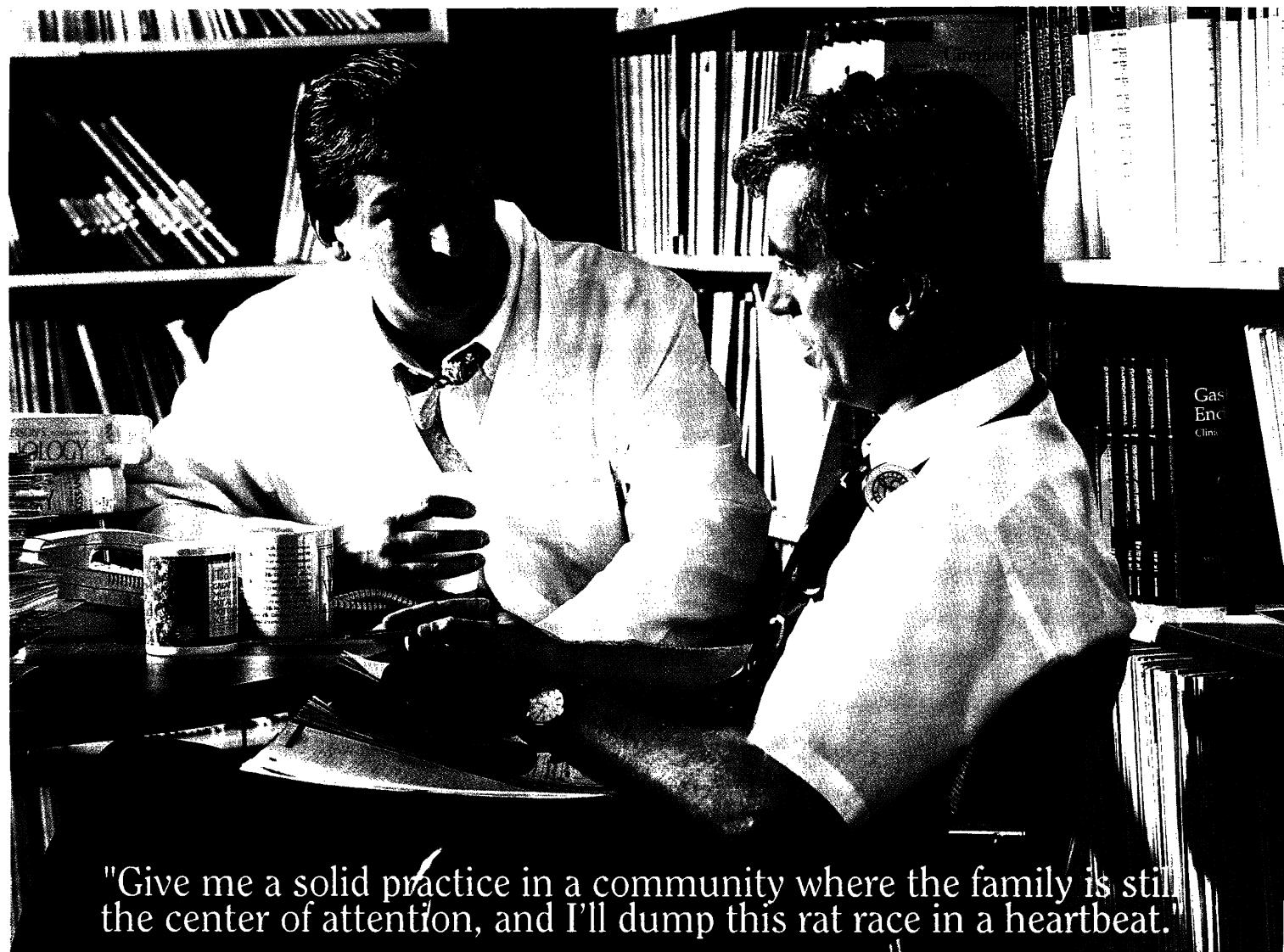
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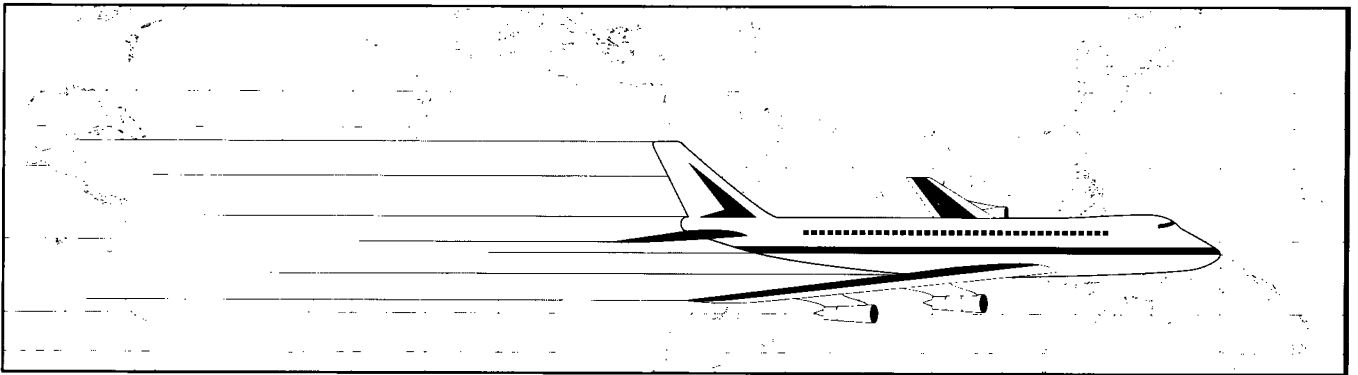
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# YOCON<sup>®</sup> YOHIMBINE HCl

**Description:** Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

**Action:** Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors. Its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

**Indications:** Yocon<sup>®</sup> is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

**Contraindications:** Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

**Warning:** Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.<sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally.<sup>1,3</sup>

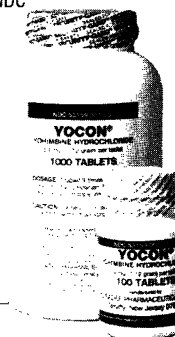
**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

**How Supplied:** Oral tablets of Yocon<sup>®</sup> 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

#### References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Topic	Date	Location
Infectious Disease in Clinical Practice	January 21-28	Snowmass, Colorado
Occupational & Environmental Medicine	January 30 February 3	Miyako Hotel, SF
Primary Care Medicine	February 19-24	Squaw Valley, California
Diabetes Update Advances in Endocrinology & Metabolism	March 17-18	Ritz Carlton, San Francisco
Emergency Medicine The Next 100 Years Paramedic Centennial Program	March 23-24	Holiday Inn, Financial Dist. San Francisco
Primary Care Cardiology	April 1	ANA Hotel, San Francisco

Topic	Date	Location
Advances in Emergency Medicine	April 5-8	Ritz Carlton, San Francisco
Primary Care Update	April 16-21	Maui Inter- continental Hotel, Maui, HI
Advances in Infectious Diseases	April 26-28	Fairmont Hotel San Francisco
Advances in Internal Medicine	May 22-26	Ritz Carlton, San Francisco
Advances in Internal Medicine	June 19-23	UCSF Campus, San Francisco

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against allergic rhinitis*

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*See charts on reverse side*

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**Onset of action as early as 12 hours**

*Maximum benefit is generally seen within 3 to 4 days*

**Excellent safety profile**

*No measurable effect on HPA function at  
recommended doses*

*The most commonly reported side effects  
are headache and nasal irritation*

ONCE DAILY

**Flonacort**<sup>®</sup>

Nasal  
Inhaler

(triamcinolone acetonide)

*Please see brief summary of prescribing  
information on following page.*

# ONCE DAILY Nasacort<sup>®</sup> (triamcinolone acetonide) Nasal Inhaler

## For Intranasal Use Only Shake Well Before Using

### BRIEF SUMMARY

**CONTRAINDICATIONS:** Hypersensitivity to any of the ingredients of this preparation contraindicates its use.

**WARNINGS:** The replacement of a systemic corticosteroid with a topical corticosteroid can be accompanied by signs of adrenal insufficiency and, in addition, some patients may experience symptoms of withdrawal, e.g., joint and/or muscular pain, lassitude and depression. Patients previously treated for prolonged periods with systemic corticosteroids and transferred to topical corticosteroids should be carefully monitored for acute adrenal insufficiency in response to stress. In those patients who have asthma or other clinical conditions requiring long-term systemic corticosteroid treatment, too rapid a decrease in systemic corticosteroids may cause a severe exacerbation of their symptoms.

Children who are on immunosuppressant drugs are more susceptible to infections than healthy children. Chickenpox and measles, for example, can have a more serious or even fatal course in children on immunosuppressant doses of corticosteroids. In such children, or in adults who have not had these diseases, particular care should be taken to avoid exposure. If exposed, therapy with varicella zoster immune globulin (VZIG) or pooled intravenous immunoglobulin (IVIG), as appropriate, may be indicated. If chickenpox develops, treatment with antiviral agents may be considered.

The use of Nasacort Nasal Inhaler with alternate-day systemic prednisone could increase the likelihood of hypothalamic-pituitary-adrenal (HPA) suppression compared to a therapeutic dose of either one alone. Therefore, Nasacort Nasal Inhaler should be used with caution in patients already receiving alternate-day prednisone treatment for any disease.

### PRECAUTIONS

**General:** In clinical studies with triamcinolone acetonide administered intranasally, the development of localized infections of the nose and pharynx with *Candida albicans* has rarely occurred. When such an infection develops it may require treatment with appropriate local therapy and discontinuance of treatment with Nasacort Nasal Inhaler.

Triamcinolone acetonide administered intranasally has been shown to be absorbed into the systemic circulation in humans. Patients with active rhinitis showed absorption similar to that found in normal volunteers. Nasacort at 440 mcg/day for 42 days did not measurably affect adrenal response to a six hour cosyntropin test. In the same study prednisone 10 mg/day significantly reduced adrenal response to ACTH over the same period (see CLINICAL TRIALS section).

Nasacort Nasal Inhaler should be used with caution, if at all, in patients with active or quiescent tuberculous infections of the respiratory tract or in patients with untreated fungal, bacterial, or systemic viral infections or ocular herpes simplex.

Because of the inhibitory effect of corticosteroids on wound healing in patients who have experienced recent nasal septal ulcers, nasal surgery or trauma, a corticosteroid should be used with caution until healing has occurred. As with other nasally inhaled corticosteroids, nasal septal perforations have been reported in rare instances.

When used at excessive doses, systemic corticosteroid effects such as hypercorticism and adrenal suppression may appear. If such changes occur, Nasacort Nasal Inhaler should be discontinued slowly, consistent with accepted procedures for discontinuing oral steroid therapy.

**Information for Patients:** Patients being treated with Nasacort Nasal Inhaler should receive the following information and instructions.

Patients who are on immunosuppressant doses of corticosteroids should be warned to avoid exposure to chickenpox or measles and, if exposed, to obtain medical advice.

Patients should use Nasacort Nasal Inhaler at regular intervals since its effectiveness depends on its regular use. A decrease in symptoms may occur as soon as 12 hours after starting steroid therapy and generally can be expected to occur within a few days of initiating therapy in allergic rhinitis. The patient should take the medication as directed and should not exceed the prescribed dosage. The patient should contact the physician if symptoms do not improve after three weeks, or if the condition worsens. Nasal irritation and/or burning or stinging after use of the spray occur only rarely with this product. The patient should contact the physician if they occur.

For the proper use of this unit and to attain maximum improvement, the patient should read and follow the accompanying patient instructions carefully. Because the amount dispensed per puff may not be consistent, it is important to shake the canister well. Also, the canister should be discarded after 100 actuations.

**Carcinogenesis, Mutagenesis:** No evidence of treatment-related carcinogenicity was demonstrated after two years of once daily oral administration of triamcinolone acetonide at a maximum daily dose of 1.0 mcg/kg/day (6.1 mcg/m<sup>2</sup>/day) in male or female rats and 3.0 mcg/kg/day (12.9 mcg/m<sup>2</sup>/day) in male or female mice.

**Impairment of Fertility:** Male and female rats which were administered oral triamcinolone acetonide at doses as high as 15 mcg/kg/day (110 mcg/m<sup>2</sup>/day, as calculated on a surface area basis) exhibited no evidence of impaired fertility. The maximum human dose for comparison is 6.3 mcg/kg/day (240 mcg/m<sup>2</sup>/day). However, a few female rats which received maternally toxic doses of 8 or 15 mcg/kg/day (60 mcg/m<sup>2</sup>/day or 110 mcg/m<sup>2</sup>/day, respectively, as calculated on a surface area basis) exhibited dystocia and prolonged delivery. Developmental toxicity, which included increases in fetal resorptions and stillbirths and decreases in pup body weight and survival, also occurred at the maternally toxic doses (2.5 - 15.0 mcg/kg/day or 20 - 110 mcg/m<sup>2</sup>/day, as calculated on a surface area basis). Reproductive performance of female rats and effects on fetuses and offspring were comparable between groups that received placebo and non-toxic or marginally toxic doses (0.5 and 1.0 mcg/kg/day or 3.8 mcg/m<sup>2</sup>/day and 7.0 mcg/m<sup>2</sup>/day).

**Pregnancy:** Pregnancy Category C. Like other corticosteroids, triamcinolone acetonide has been shown to be teratogenic in rats and rabbits. Teratogenic effects, which occurred in both species at 0.02, 0.04 and 0.08 mg/kg/day (approximately 135, 270 and 540 mcg/m<sup>2</sup>/day in the rat and 320, 640 and 1280 mcg/m<sup>2</sup>/day in the rabbit, as calculated on a surface area basis), included a low incidence of cleft palate and/or internal hydrocephaly and axial skeletal defects. Teratogenic effects, including CNS and cranial malformations, have also been observed in non-human primates at 0.5 mg/kg/day (approximately 6.7 mcg/m<sup>2</sup>/day). The doses of 0.02, 0.04, 0.08, and 0.5 mg/kg/day used in these toxicology studies are approximately 12.8, 25.5, 51, and 318.7 times the minimum recommended dose of 110 mcg of Nasacort per day based on a patient body weight of 70 kg. Administration of aerosol by inhalation to pregnant rats and rabbits produced embryotoxic and fetotoxic effects which were comparable to those produced by administration by other routes. There are no adequate and well-controlled studies in pregnant women. Triamcinolone acetonide should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Experience with oral corticosteroids since their introduction in pharmacologic as opposed to physiologic doses suggests that rodents are more prone to teratogenic effects from corticosteroids than humans. In addition, because there is a natural increase in glucocorticoid production during pregnancy, most women will require a lower exogenous steroid dose and many will not need corticoid treatment during pregnancy.

**Nonteratogenic Effects:** Hypoadrenalism may occur in infants born of mothers receiving corticosteroids during pregnancy. Such infants should be carefully observed.

**Nursing Mothers:** It is not known whether triamcinolone acetonide is excreted in human milk. Because other corticosteroids are excreted in human milk, caution should be exercised when Nasacort Nasal Inhaler is administered to nursing women.

**Pediatric Use:** Safety and effectiveness have not been established in children below the age of 12. Oral corticosteroids have been shown to cause growth suppression in children and teenagers, particularly with higher doses over extended periods. If a child or teenager on any corticoid appears to have growth suppression, the possibility that they are particularly sensitive to this effect of steroids should be considered.

**ADVERSE REACTIONS:** In controlled and uncontrolled studies, 1257 patients received treatment with intranasal triamcinolone acetonide. Adverse reactions are based on the 567 patients who received a product similar to the marketed Nasacort canister. These patients were treated for an average of 48 days (range 1 to 117 days). The 145 patients enrolled in uncontrolled studies received treatment from 1 to 820 days (average 332 days).

The most prevalent adverse experience was headache, being reported by approximately 18% of the patients who received Nasacort. Nasal irritation was reported by 2.8% of the patients receiving Nasacort. Other nasopharyngeal side effects were reported by fewer than 5% of the patients who received Nasacort and included: dry mucous membranes, naso-sinus congestion, throat discomfort, sneezing, and epistaxis. The complaints do not usually interfere with treatment and in the controlled and uncontrolled studies approximately 1% of patients have discontinued because of these nasal adverse effects.

In the event of accidental overdose, an increased potential for these adverse experiences may be expected, but systemic adverse experiences are unlikely (see OVERDOSAGE section).

**OVERDOSAGE:** Acute overdosage with this dosage form is unlikely. The acute topical application of the entire 15 mg of the canister would most likely cause nasal irritation and headache. It would be unlikely to see acute systemic adverse effects if the nasal application of the 15 mg of triamcinolone acetonide was administered all at once.

**Caution:** Federal (U.S.A.) law prohibits dispensing without prescription.

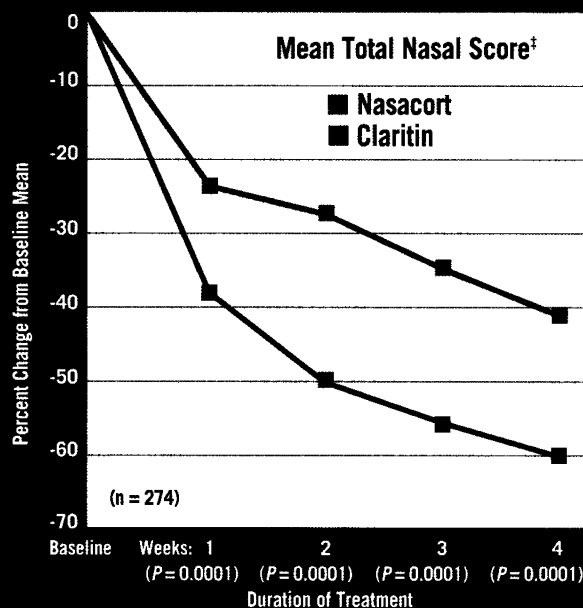
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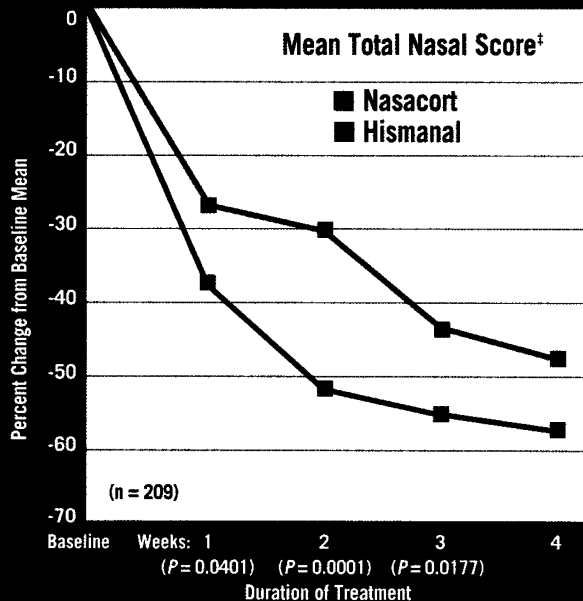
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<sup>†</sup> Total nasal score is the sum of nasal congestion, rhinorrhea, postnasal drip, sneezing, and nasal itch.



<sup>\*</sup> Claritin (loratadine) is a registered trademark of Schering Corporation.

<sup>†</sup> Each study was a double blind, randomized, multicenter, parallel group, controlled study divided into a screening period of up to 28 days which included a drug free baseline period (the last 5 days of the screening period) and a double-blind active treatment period of 4 weeks (28 days).

<sup>‡</sup> Hismanal (astemizole) is a registered trademark of Janssen Pharmaceutica Inc.

### REFERENCES

1. Data on file, Protocol RG-5029-604 (Nasacort vs. Claritin), Rhône-Poulenc Rorer Pharmaceuticals Inc.
2. Data on file, Protocol RG-5029-603 (Nasacort vs. Hismanal), Rhône-Poulenc Rorer Pharmaceuticals Inc.
3. Data on file, Protocol CTA 0393 (triamcinolone acetonide vs. placebo), Rhône-Poulenc Rorer Pharmaceuticals Inc.
4. Ziemniak JA: Pharmacokinetics of intranasal triamcinolone acetonide. *J Respir Dis* 1991;12(3, Suppl): S11-S42.
5. Feiss G, Morris R, Rom D, et al: A comparative study of the effects of intranasal triamcinolone acetonide aerosol (ITAA) and prednisone on adrenocortical function. *J Allergy Clin Immunol* 1992;89(6):1151-1156.

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**YELLOWSTONE NATIONAL PARK.** Physician to cover outpatient clinic, Emergency Room, and inpatient at Lake Hospital from Memorial Day to mid September 1995. Send CV to Yellowstone Park Medical Services, 707 Sheridan Ave, Cody, WY 82414 or call (307) 578-2461.

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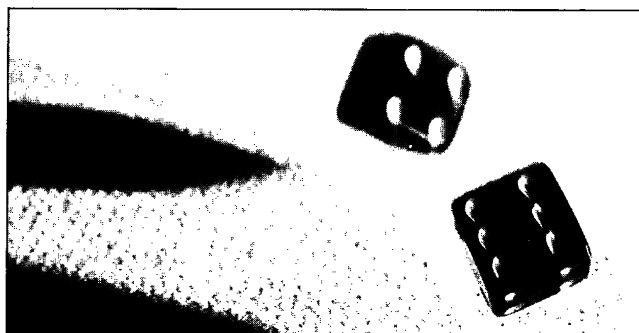
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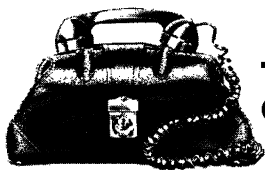
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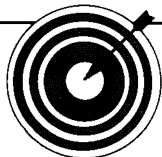


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